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Multidisciplinary team in temporomandibular disorders

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ABSTRACT

Introduction: The temporomandibular disorders (TMD) are one of the main concerns regarding orofacial pathologies and there are an ascending number of cases. They are characterised as a group of pathological conditions that may affect the temporomandibular joint (TMJ), the masticatory musculature and/or other adjacent anatomical structures, leading to pain and dysfunction [1]. The multifactorial aetiology of TMD affects a relatively large number of the world population and requires a multidisciplinary evaluation and diagnosis by the clinical team [2]. Among the various elements that constitute the multidisciplinary team we highlight the dentist and the physiotherapist. The dentist as a first-line professional, most of the time is responsible for the identification of patients potentially at risk and for the follow-up of those who already present the disease [3]. On the other hand, the physiotherapist aims to reduce musculoskeletal pain, promote muscle relaxation, reduce muscle hyperactivity, improve function by restoring the quality and quantity of mandibular movements and maximise joint mobility [4].

Description of the clinical case: A 24-year-old female patient with a history of temporomandibular disorder and bruxism she presented a non-assisted mouth opening (UMO) of 28 mm and an assisted mouth opening with pain in the masseter and TMJ bilaterally of 29 mm, after the clinical assessment with the DC/TMD protocol we arrived at a diagnosis of disc displacement without reduction (DDwR) with limited opening, degenerative joint disease in the left TMJ, arthralgia (II), myofascial pain (III) in the masseter with pain referred to other anatomical regions. All the assumptions of the Helsinki Declaration have been fulfilled and an informed consent for clinical case of Clínica Dentária Egas Moniz approved by the ethic commission of Instituto Universitário Egas Moniz. The treatment plan consisted of cognitive behavioural therapy (CBT), prescription of muscle relaxants, occlusal splint especially for reduction of overload due to bruxism, infiltration with 1 ml of hyaluronic acid of high molecular weight in the TMJ bilaterally followed by articular mobilisation techniques and neuromuscular and myofascial techniques. The patient was instructed to continue with the physiotherapy.

Results: The follow up was made 2 months after with 8 sessions of physiotherapy and 1 more hyaluronic acid infiltration bilaterally as protocolled session, we could observe an absence of temporomandibular joint pain, UMO of 42 mm, decreased crepitation, decreased intensity of myofascial pain (I) and (DDwR) without limited opening.

Discussion and conclusion: The multidisciplinary dentist-physiotherapist team combines inputs from different professions with the aim of promoting the best patient care and represents an added value for the management of the signs/symptoms of patients with temporomandibular dysfunction.

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My tooth is ill: about the mental representation of the concept of caries in children (phase I)

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ABSTRACT

Introduction: Dental caries has a negative impact on children's oral health-related quality of life (QVRSO) [1], suggesting the need to understand how the oral clinical condition may interfere with the child's daily life. The acquisition of information that interacts with the child's mental schemas consolidates her ability to think inter and intrapsychic thought and knowledge of the world around her [2]. Same happens with the mental representation of the concept of caries that consequently influences the internalisation of salutogenic habits at the level of the biopsychosocial development of the infant patient [3]. In the present study we intend to evaluate the mental representation that children internalise about the concept of dental caries.

Materials and methods: The sample of the present study consists of a total of 880 children, from 4 to 9 years, of both genders (51.7% girls, 48.3% boys).

Instruments: (i) Sociodemographic questionnaire, data on age, sex, schooling and whether or not the participant has already resorted to a Dental Medicine consultation.

Procedures: Data was collected at two moments: M1, where the child was asked to draw a *Healthy Tooth* on a sheet of paper and M2, where the child was asked to draw a *Sick Tooth* on another sheet using only a pencil of graphite and no rubber. Subsequently, the child was asked to respond to an open-ended questionnaire composed by three distinct questions, with the aim of evaluating the mental representation of the concept of (a) *Dental decay*, (b) *Healthy teeth* and (c) *Sick teeth*. NVivo software was used in order to carry out the content analysis of the written narrative, referring only to the first question (a) What is a dental decay for you?. The written answers were subjected to a content analysis grid that encompasses 13 elementary analytical categories.

Results: Of note, 611 children who participated in the study had already attended a Dental Medicine consultation (69.4%), while 269 (30.6%) had never visited a health care unit. According to the results obtained in relation to the question (a) *What is a dental decay for you?*, 13 categories were created in which six were prominent, which seem to illustrate the mental representation of the concept of dental decay in this age group, namely: *Do not know* (18.5%), *Bugs/Monsters* (16.7%), *Teeth damage* (11%), *Bad oral hygiene* (9.6%), *Rotten tooth* (7.9%), *Teeth colouration* (7.3%), being curiously the category Bacteria, only referenced with a percentage of 2.2%.

Discussion and conclusions: Since caries is an aetiological source of pain and malaise, it is important to recognise the mental perception of children about this concept, in order to contribute to the (re) conceptualisation of the concept of Oral Health Education, to the level of caries aetiology.

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